

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5645

## CERTIFICATE OF DEATH

05640

Reg. Dist. No. 350

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke</b>		c. LENGTH OF STAY IN 1b <b>30 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>911 Clarke Ave.</b>		d. STREET ADDRESS <b>911 Clarke Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>W.</b> Last <b>BAILEY</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1895</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>60</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Section Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna. R. R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William R. Bailey</b>		14. MOTHER'S MAIDEN NAME <b>Anna Peacarr</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>717-07-9068</b>	
17. INFORMANT <b>Lottie M. Bailey, Pocomoke, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> DUE TO <b>ARTERIOSCLEROTIC HEART DISEASE</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. (b) <b>10 YEARS</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>STRENUOUS WORK</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Pocomoke City, Worcester, Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEB 11</b> , 19 <b>56</b> , to <b>MAY 10</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>MAY 10</b> , 19 <b>56</b> , and that death occurred at <b>7<sup>20</sup> P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. Stanford Hamilton</b> M.D.		ADDRESS (Street, city or town, state) <b>Front St. Pocomoke City, Md.</b> DATE SIGNED <b>5-11-56</b>	
PHYSICIAN'S NAME (Type) <b>C. Stanford Hamilton, M. D., Pocomoke, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/13/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Salem Methodist Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry L. Watson</b> ADDRESS <b>Pocomoke, Md.</b>		24a. REC'D BY REGISTRAR <b>5/15/56</b> 24b. REGISTRAR'S SIGNATURE <b>Anne Hunter</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the name of the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 15 1956

RECEIVED

05641

MARYLAND Item 9, Film G-199, 6/28/56 rs

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

5648

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
TOWN <u>Berlin</u>		TOWN <u>Berlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Rt. 1</u>	
3. NAME OF DECEASED (Type or Print) <u>Lizzie</u> (First) <u>Birch</u> (Middle) (Last)		4. DATE OF DEATH <u>May</u> (Month) <u>25</u> (Day) 19 <u>56</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widow</u>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>72</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Filmore Dennis</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Calvin Birch Berlin Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Coronary thrombosis</u>		<u>2 days</u>
(b) Antecedent cause(s) <u>Coronary heart disease &amp; Seminal</u>		<u>10 yrs</u>
(c) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last <u>Arteriosclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS <u>Diabetes mellitus &amp; Acidosis</u>		<u>20 yrs</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY?		Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1952, to May 25, 1956, that I last saw the deceased alive on May 25, 1956, and that death occurred at 3 m., from the causes and on the date stated above.

SIGNATURE Herman Kabin (Degree or title) Berlin, Maryland ADDRESS Berlin, Maryland DATE SIGNED May 25, 1956

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE <u>5/27/56</u>	NAME OF CEMETERY OR CREMATORY <u>Waverly</u>	LOCATION (City, town, or county) (State) <u>Berlin Md.</u>
DATE REC'D BY LOCAL REG. <u>5/28/56</u>	REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>	24. FUNERAL DIRECTOR <u>Peter Whaley Delaney</u>	ADDRESS <u>Berlin Md.</u>

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAY 31 1956

RECEIVED

**MEDICAL CERTIFICATION**

VS. A15ME(5)  
5M 9/55

STATE OF MARYLAND  
DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 28 1956

RECEIVED



5649

## CERTIFICATE OF DEATH

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>none</u> Middle <u>none</u> Last <u>Blake</u>		4. DATE OF DEATH <u>May</u> Month <u>27</u> Day <u>1956</u> Year	
5. SEX <u>2</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 4 '56</u>
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>2</u> Days <u>16</u> Hours <u>30</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Stockton, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Richard Henry Collins</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Eva Blake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Annice Blake</u>		Address <u>Stockton, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage - from cord.</u> 760.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tracheal tying or unusual shrinking of cord</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mother &amp; family did not call doctor for after bleeding</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>5:00</u> 19 <u>56</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>after death</u> , to <u>1956</u> , that I last saw the deceased alive on <u>May 27</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>N. E. Sartorius</u> M.D.		ADDRESS (Street, city or town, state) <u>Pocomoke City, Md</u>	
PHYSICIAN'S NAME (Type) <u>N. E. Sartorius</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>May 28</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Coole Springs</u>		22d. LOCATION (City, town, or county) (State) <u>Stockton, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne E. Smith</u>		ADDRESS <u>Snow Hill, Md</u>	
24a. REC'D BY REGISTRAR <u>Wayne E. Smith</u>		24b. REGISTRAR'S SIGNATURE <u>Elwyn Cooper</u>	
DATE <u>MAY 31 1956</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BUREAU V. 8

MAY 31 1956

RECEIVED



5651

## CERTIFICATE OF DEATH

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Stockton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Stockton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Eva</u> First <u>Lee</u> Middle <u>Brown</u> Last		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 29th 1892</u>
9. AGE (In years last birthday) <u>63</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Woodbury, N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Thomas Savage</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Elizabeth White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Rw. Angelot Brown</u> Address <u>Husband</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> <u>420.1</u> DUE TO <u>Cardio Vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Second</u> DUE TO (c) <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia. 3 weeks ago</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dead when I saw her</u> to <u>1956</u> , that I last saw the deceased alive on <u>May 14</u> , 19 <u>56</u> , and that death occurred on <u>May 20</u> , 19 <u>56</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. J. Sartorius</u> M.D.		ADDRESS (Street, city or town, state) <u>Pocomoke City, Md.</u>	
PHYSICIAN'S NAME (Type) <u>R. J. Sartorius</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-25-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Whorton</u>		ADDRESS <u>New Church, Md.</u>	
24a. REC'D BY REGISTRAR <u>May 25, 56</u>		24b. REGISTRAR'S SIGNATURE <u>Elmer E. Cooper</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filed in the hospital or attending physician's file. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

BUREAU V. S.

JUN 7 1956

RECEIVED

5652

CERTIFICATE OF DEATH

05644

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>M.D.</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>			
c. LENGTH OF STAY IN 1b <u>10 yrs.</u>				d. STREET ADDRESS <u>NORTH MAIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DORRIS ALVETA BURBAGE</u>				4. DATE OF DEATH Month Day Year <u>MAY 30 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>	
11. BIRTHPLACE (State or foreign country) <u>SELBYVILLE, DEL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>EDWARD LONG</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE K. HUDSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>MR. JOHN HOWARD BURBAGE BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, generalized (started in stomach)</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> to <u>5-30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-30</u> , 19 <u>56</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank R. Lewis</u> M.D. <u>Willards Maryland</u>				DATE SIGNED <u>5-30-56</u>			
PHYSICIAN'S NAME (Type) <u>Frank R. Lewis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 1, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage Berlin Ind.</u> ADDRESS <u>Berlin Ind.</u>				24a. REC'D BY REGISTRAR <u>DATE 5/30/56</u>		24b. REGISTRAR'S SIGNATURE <u>Helen G. Hayward</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. S.

JUN 8 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5653

## CERTIFICATE OF DEATH

05645  
351

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Stockton</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Stockton</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Isaac</u> Middle <u>J.</u> Last <u>Hancock</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18, 1864</u>
9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Hancock</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Redden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>---</u>	
17. INFORMANT <u>Mrs Samuel L. Tarr, Stockton, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Oedema</u> <u>422.2</u> DUE TO <u>Cardiac Decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Degenerative Heart Disease</u> (c) <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>37 months</u> <u>7 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1, 1956</u> , to <u>May 13, 1956</u> , that I last saw the deceased alive on <u>May 13, 1956</u> , and that death occurred at <u>11:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Pocomoke City, Md.</u> DATE SIGNED <u>4-15-56</u>			
ACTUAL SIGNATURE <u>Charles W. Trader</u> M.D.		PHYSICIAN'S NAME (Type) <u>Charles W. Trader, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 16, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Porterville M.E. Cemetery, Porterville, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Watson</u>		ADDRESS <u>Pocomoke, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Cheryl Cooper</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>		AGE <i>45</i>	
DATE OF DEATH <i>May 10, 1956</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		OCCUPATION <i>Teacher</i>		EDUCATION <i>High School</i>	
BIRTH DATE <i>May 15, 1911</i>		BIRTH PLACE <i>Baltimore, Md</i>		MARRIAGE DATE <i>Jan 1, 1935</i>	
MARRIAGE PLACE <i>Baltimore, Md</i>		SPOUSE NAME <i>Jane Doe</i>		SPOUSE BIRTH DATE <i>Aug 1, 1912</i>	
SPOUSE BIRTH PLACE <i>Baltimore, Md</i>		SPOUSE OCCUPATION <i>Homemaker</i>		SPOUSE EDUCATION <i>High School</i>	
DECEASED'S RESIDENCE <i>123 Main St, Baltimore, Md</i>		DECEASED'S OCCUPATION <i>Teacher</i>		DECEASED'S EDUCATION <i>High School</i>	
DECEASED'S RELIGION <i>Catholic</i>		DECEASED'S RACE <i>White</i>		DECEASED'S ETHNIC ORIGIN <i>None</i>	
DECEASED'S MARITAL STATUS <i>Married</i>		DECEASED'S SOCIAL SECURITY NUMBER <i>123-45-6789</i>		DECEASED'S MEDICAL HISTORY <i>None</i>	
DECEASED'S PREVIOUS ILLNESS <i>None</i>		DECEASED'S PREVIOUS SURGERY <i>None</i>		DECEASED'S PREVIOUS TRAUMA <i>None</i>	
DECEASED'S PREVIOUS DRUG USE <i>None</i>		DECEASED'S PREVIOUS ALCOHOL USE <i>None</i>		DECEASED'S PREVIOUS TOBACCO USE <i>None</i>	
DECEASED'S PREVIOUS OTHER <i>None</i>		DECEASED'S PREVIOUS OTHER <i>None</i>		DECEASED'S PREVIOUS OTHER <i>None</i>	

RECEIVED  
MAY 17 1956  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5654 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05646  
350

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Worcester</span> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Pocomoke City RURAL 45 yrs</span> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Worcester</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">RURAL Pocomoke City</span> d. STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-around;"> <span>First <span style="font-size: 1.2em;">Esley</span></span> <span>Middle <span style="font-size: 1.2em;">T.</span></span> <span>Last <span style="font-size: 1.2em;">Mariner</span></span> </div>		<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-around;"> <span>Month <span style="font-size: 1.2em;">May</span></span> <span>Day <span style="font-size: 1.2em;">31</span></span> <span>Year <span style="font-size: 1.2em;">1956</span></span> </div>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>	<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Feb 27, 1889</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">67 yrs.</span>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Farmer</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Farming</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Virginia</span>			
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">William D. Mariner</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Charlotte Ailsworth</span>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">no</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">213-05-2011</span>		<b>17. INFORMANT</b> Address <span style="font-size: 1.2em;">Mrs Effie A. Mariner, Pocomoke, Md.</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] <div style="display: flex;"> <div style="flex: 1;"> <b>PART I. DEATH WAS CAUSED BY:</b>            IMMEDIATE CAUSE (a)  <span style="font-size: 1.5em;">420.1</span> DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.            (b)            (c)         </div> <div style="flex: 2; font-family: cursive;"> <span style="font-size: 1.5em;">Coronary Occlusion</span>  <span style="font-size: 1.5em;">Hypertensive Vascular Disease</span> </div> <div style="flex: 1; font-size: 0.8em;">           INTERVAL BETWEEN ONSET AND DEATH         </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.2em;">N. E. Sartorius M.D.</span>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">N. E. Sartorius</span>		<b>DATE SIGNED</b> <span style="font-size: 1.5em;">5/31/56</span>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>	<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">June 3, 1956</span>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Baptist Cemetery</span>	<b>22d. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Pocomoke City, Maryland</span>				
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">Henry H. Watson</span>		<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">Pocomoke, Md.</span>					
<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Rose White</span>		<b>DATE</b> <span style="font-size: 1.2em;">JUN 4</span>					

MEDICAL CERTIFICATION

TO THE FUNERAL EXAMINER: This certificate should be executed within 24 hours after death. If only one copy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

RECEIVED  
JUN 4 1956  
BUREAU V. S.

5646

## CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>904 Walnut Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Susie</b> Middle <b>E.</b> Last <b>Messick</b>				4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 30, 1874</b>	
9. AGE (In years last birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George T. Collins</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Powell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>---</b>		17. INFORMANT Address <b>Miss Myra Messick, Pocomoke City, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Paralysis of throat</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Cardio Vascular disease</b> (c) <b>Stroke</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Stroke with spinal lesion - 2 yrs ago</b> INTERVAL BETWEEN ONSET AND DEATH <b>Two days</b> <b>years</b> <b>71</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Dec 9th 1954</b> to <b>April 30 56</b> , that I last saw the deceased alive on <b>April 30, 1956</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>N. E. Sartorius, Sr.</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>Pocomoke City, Md.</b>			
PHYSICIAN'S NAME (Type) <b>N. E. Sartorius, Sr.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-3-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baptist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Watson</b>				ADDRESS <b>Pocomoke, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 5/4/56</b>	
24b. REGISTRAR'S SIGNATURE <b>Anne White</b>							

ENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

TO HOSPITAL OR THE hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAY 4 1956

RECEIVED

1  
OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4  
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G198 6-15-56 et

05648

5647

CERTIFICATE OF DEATH

Reg. Dist. No.

350

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> 42	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Matthew</u> First <u>Purnell</u> Middle <u>Purnell</u> Last		4. DATE OF DEATH <u>May 31</u> Month <u>1956</u> Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 22-1898</u> 57 yr
9. AGE (In years last birthday) <u>57</u>		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work, Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>	
13. FATHER'S NAME <u>Richard Holland</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Purnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give dates of service)		16. SOCIAL SECURITY NO. <u>219-7-1635</u>	
17. INFORMANT <u>Richard Holland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>603X</u> DUE TO <u>Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial obstruction</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity - Hospital refused</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/22</u> , 19 <u>56</u> , to <u>May 31</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>May 30</u> , 19 <u>56</u> , and that death occurred at <u>Pocomoke City</u> , M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>N. E. Sartorius</u> M.D.		ADDRESS (Street, city or town, state) <u>Pocomoke City MD</u> DATE SIGNED <u>5/31/56</u>	
PHYSICIAN'S NAME (Type) <u>N. E. Sartorius</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-4-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Halls Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Pocomoke Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 6/4/56</u> 24b. REGISTRAR'S SIGNATURE <u>Anne White</u>	



CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint markings.

BUREAU V. S.

JUN 6 1956

RECEIVED



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5655

## CERTIFICATE OF DEATH

05649

Reg. Dist. No. 351

1. PLACE OF DEATH COUNTY <i>Worcester</i> MARYLAND CITY OR TOWN <i>Snow Hill</i> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MD</i> COUNTY <i>Worcester</i> CITY OR TOWN <i>Snow Hill</i> STREET ADDRESS	
3. NAME OF DECEASED (Type or Print) <i>Sarah E. Richardson</i>		4. DATE OF DEATH (Month) <i>May</i> (Day) <i>7</i> (Year) <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>July 5-1871</i>
9. AGE last birthday <i>84</i> yrs.		10. AGE last birthday <i>84</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Newark MD</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Benjamin Twigg</i>		14. MOTHER'S MAIDEN NAME <i>Leah Boston</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, counts) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT & ADDRESS <i>Mr. Harry W. Richardson</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <i>Pulmonary Edema - acute</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive Cardiovascular disease</i>		<i>5 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Right Hemiplegia - Cerebrovascular accident</i>		<i>one day</i>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>May 6</i> , 19 <i>56</i> , to <i>May 7</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>May 6</i> , 19 <i>56</i> , and that death occurred at <i>3:50</i> P.M. from the causes and on the date stated above.			
SIGNATURE <i>Deborah L. Laker</i>		DATE SIGNED <i>5/7/56</i>	
ADDRESS (Street, city, town, state) <i>104 Bay St. Snow Hill, Md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>May 9/56</i>	
NAME OF CEMETERY OR CREMATORY <i>St. Olive Cemetery</i>		LOCATION (City, town, or county) (State) <i>Snow Hill, Worcester Co. MD</i>	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <i>Laura E. Cooper</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Walter E. Danner</i>	
DATE <i>May 9, 1956</i>		ADDRESS <i>Snow Hill, MD</i>	

CERTIFICATE OF DEATH

File On No.

At the County of Middlesex, State of Massachusetts

DATE

DECEASED

TIME OF DAY

PLACE

AGE

SEX

RACE

RELATIONSHIP

EDUCATION

PROFESSION

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

DIAGNOSIS

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

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DATE OF RECREATION

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PLACE OF REINTERMENT

*John J. Thompson - 1000 - 1000*

*John J. Thompson - 1000 - 1000*

BUREAU V. 8

JUN 7 1956

RECEIVED

*John J. Thompson*

*John J. Thompson*

## INSTRUCTIONS

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05650

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## CERTIFICATE OF DEATH

Reg. Dist. No. 351

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Mercer</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Mercer</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		LENGTH OF STAY (in this place) <i>1 yr</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <i>R.</i> (Middle) <i>Scott</i> (Last) <i>Ritchie</i>				(Month) <i>May</i> (Day) <i>21</i> (Year) <i>1956</i>			
<b>5. SEX</b> <i>Male</i>	<b>6. COLOR OR RACE</b> <i>White</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Widowed</i>	<b>8. DATE OF BIRTH</b> <i>June 20-1865</i>		<b>9. AGE last birthday</b> <i>100/11/1</i> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Own Farm</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Salisbury, md</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <i>George Ritchie</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Mary Kelly</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, No, or unk.) (If Yes, give war or dates of service) <i>No</i>				<b>16. SOCIAL SECURITY NO.</b> <i>None</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Miss Mallie Ritchie, Snow Hill, md</i>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>IMMEDIATE CAUSE (A)</b> <i>422.2 Acute Pulmonary Edema</i>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>1 day</i>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <i>Congestive Cardiac Failure</i>						<i>1 yr</i>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <i>Myocardial Insufficiency</i>						<i>2 yrs</i>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>Arteriosclerotic - Vascular</i>						<i>15 yrs.</i>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>				<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from 1946, 19, to May 21, 1956, that I last saw the deceased alive on May 19, 1956, and that death occurred at 2:50 PM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Robert L. Lamer</i>				<b>ADDRESS (Street, city, town, state)</b> <i>M.D. 104 Bay St. Snow Hill, md</i>		<b>DATE SIGNED</b> <i>5/21/56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>May 23/56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Whitaker Cemetery</i>		<b>LOCATION (City, town or county)</b> <i>Snow Hill, md</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Clara E. Cooper</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Walter Sumner</i>		<b>ADDRESS</b> <i>Snow Hill, md</i>	
<b>DATE</b> <i>May 24, 1956</i>							

# CERTIFICATE OF DEATH

5036

1. DECEASED'S NAME (Last, first, middle)

2. SEX  
 3. AGE  
 4. DATE OF BIRTH  
 5. PLACE OF BIRTH

6. MARY AND

7. DECEASED'S OCCUPATION

8. DECEASED'S RESIDENCE

9. DECEASED'S MARITAL STATUS

10. DECEASED'S RACE

11. DECEASED'S RELIGION

12. DECEASED'S EDUCATION

13. DECEASED'S SERVICE

14. DECEASED'S SOCIAL SECURITY NUMBER

15. DECEASED'S DATE OF DEATH

16. DECEASED'S TIME OF DEATH

17. DECEASED'S PLACE OF DEATH

18. DECEASED'S CAUSE OF DEATH

19. DECEASED'S MANNER OF DEATH

20. DECEASED'S SIGNATURE

21. DECEASED'S ADDRESS

22. DECEASED'S CITY

23. DECEASED'S STATE

24. DECEASED'S ZIP CODE

25. DECEASED'S COUNTY

26. DECEASED'S DISTRICT

27. DECEASED'S TOWNSHIP

28. DECEASED'S PARISH

29. DECEASED'S PRECEPT

30. DECEASED'S WARD

31. DECEASED'S BEING

32. DECEASED'S VOTING DISTRICT

33. DECEASED'S CONGRESSIONAL DISTRICT

34. DECEASED'S LEGISLATIVE DISTRICT

BUREAU V. B.

JUN 7 1956

RECEIVED

MEDICAL CERTIFICATION



# CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1956



BUREAU OF VITAL STATISTICS

JUN 9 1956

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